

March 13, 2012

Ms. Marlene H. Dortch  
Secretary  
Federal Communications Commission  
445 12th Street SW  
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On February 23, 2012, representatives of five projects in the FCC's Rural Health Care Pilot Program (RHCPP) spoke via telephone with Linda Oliver, Christianna Lewis Barnhart, and Chin Yoo of the Wireline Competition Bureau. These representatives were Greg Snyder, Vice President of Technology, Pennsylvania Mountains Healthcare Alliance (PMHA); Roger Poston, Associate Program Coordinator, Palmetto State Providers Network (PSPN); and David Kirby, Project Manager, North Carolina Telehealth Network (NCTN). Additionally, Steven Summer, President and CEO, Colorado Hospital Association; George DelGrosso, Executive Director, Colorado Behavioral Health Council; Debby Farreau, Program Director, Colorado Telehealth Network; and Jeff Richardson, Principal Consultant, Colorado Telehealth Network participated in the call on behalf of Colorado Health Care Connections (CHCC) and Rocky Mountain HealthNet (RMHN). Due to their proximity to each other, CHCC and RMHN have been working closely together and provided their comments during the call as one entity, the Colorado Telehealth Network (CTN). The purpose of the call was to discuss the telecommunications needs of rural health care providers (HCPs) in response to the Commission's July 15, 2010 Notice of Proposed Rulemaking in the above-referenced docket. The group discussed their experiences with the Pilot Program and what they felt worked or could be improved upon in the future. Below is a summary of their comments:

*Project achievements.* To date, CTN has deployed broadband to 201 HCP locations, which are split almost evenly between the two projects. The bandwidth varies from 4.5 Mbps over copper lines to smaller sites to as high as 100 Mbps for hospitals. Working as CTN on their pilot projects has had the benefit of bringing RMHN and CHCC together to work on policy and other aspects of health care. Additionally, the projects share their administration and have configured their networks so that they can communicate with each other. The broadband connections provided by CTN have made an enormous impact on cost and quality and have enormous support across a broad spectrum of participants.

The PSPN project has also spurred a great deal of collaboration across the state of South Carolina. 75 percent of South Carolina is rural and the state faces challenges similar to most rural states – high poverty levels, disparities in health care, and a paucity of specialty services. The project currently includes 120 to 150 HCPs on its network in all 46 counties in South Carolina (including all of the states' hospital emergency departments and a number of Federally Qualified Health Centers (FQHCs)). Going forward, PSPN is focused on attracting rural health clinics and other health care professionals across the state to its network.

PSPN has had a very good experience with cost savings through telehealth, including a very aggressive tele-OB/GYN program, several psychiatry programs, and many more programs ramping up at the Medical University of South Carolina. In the past, the limiting factor for telehealth in the state has been obtaining sufficient transport for video, data, and images so they could be used for medical purposes. To address these issues, the PSPN network was developed to support telemedicine (clinical encounters) and telehealth (including education), and offers a symmetrical, 10 Mbps package to its

members, including a minimum of 5 Mbps of commodity Internet and a shared Internet2 connection. It is currently seeing increased demand from HCPs to join PSPN now that it is able to demonstrate the uses of the network.

NCTN is a private network with a connection to the public Internet and Internet2, which provides connectivity beginning at 10 Mbps and with dual redundancy. It was built as a private network in order to allow members to communicate with each other without crossing the public Internet. Because it is a private network, it is more reliable and better latency control for video-based and other applications that need high reliability (e.g. remote ICU monitoring, disaster preparedness, remote electronic health records). Additionally, because many of the public health agencies on NCTN are core responders to natural disasters, it was essential to have a network that would be available in emergency response situations to encourage members to invest in the network and services.

NCTN stated that 120 HCPs have committed to participate in the NCTN network; 80 sites have already joined and another 40 expect to join soon. NCTN's sites primarily consist of hospitals, FQHCs, public health clinics, and free clinics. The network includes about 60 percent of the public health agencies and half of the hospitals in North Carolina. According to a survey conducted recently by NCTN, approximately 60 percent of telemedicine applications in North Carolina include use of an NCTN link. The NCTN was awarded the public leadership award by the NC Technology Association in 2012. There is a backlog of RHCPP-eligible sites for which RHCPP funding is not available today. The project is positioning to make use of the expected discount improvements in the upcoming RHC reform for these extra sites and to extend service for the initial RHCPP-discounted sites beyond the RHCPP's life.

PMHA is a group of 21 hospitals in central and western Pennsylvania. The project has deployed 100 Mbps links among the hospitals and provides redundant connections to ISPs in Philadelphia and Pittsburgh. PMHA noted that the benefits of pilot funding include the ability to obtain Internet services as a group, and to deploy redundant circuits for each facility. PMHA is exploring a variety of different telemedicine solutions for deployment, including teleneurology. The most significant benefit related to telemedicine to date has been the reduction in existing tele-radiology image transfer time. Many of the sites that were underserved have seen more than a 75% reduction in image transfer time during off hours and weekends.

*Administrative expenses.* The group noted that the exclusion of administrative expenses as an eligible expense in the Pilot Program was a hardship on the projects. Many projects thought that administrative expenses would be an allowable expense when they applied for Pilot Program funds, and as such, were not prepared when administrative expenses were excluded. Many projects then spent considerable amounts of time seeking funds from outside groups to cover their administrative expenses. This caused projects significant delay in getting their networks started, in some cases up to a year and a half. The group also noted that it was difficult for projects to come up with their own funds to pay for their own administrative expenses until their networks were built. Additionally, they mentioned that many rural HCPs rely on urban sites in their network to pay for their networks' administrative expenses. The group was concerned that this source of support could disappear if urban locations were no longer allowed to participate in the Rural Health Care (RHC) program.

*Urban locations.* In addition to providing support to cover rural HCPs' administrative expenses, the group also described how urban HCP participation is, as stated by CTN, "the key to the networks' success" and of value to both urban and rural HCPs. Rural HCPs value their connection to urban hospitals and their instant access to specialized care. In addition, urban HCPs have provided technical support to rural HCPs and trained some of their IT staff, which has led to an improved rural HCP workforce. Urban HCPs also benefit by participating in networks with rural HCPs and have seen a return on their investment. For example, PSPN noted that it has realized approximately one million dollars a

month in Medicaid savings as a result of its telepsychiatry program, which it operates through its network.

The group noted that the Pilot Program has demonstrated what health care can do when urban and rural HCPs work together. Accordingly, the group was concerned about how Pilot projects would be impacted if urban HCPs were no longer eligible to participate in the RHC program. Due to the current economic environment, the group noted that budgets are tight for urban HCPs. As a result, it may be difficult for urban HCPs to continue provide support to rural HCPs in their networks if they are ineligible to receive RHC program funding themselves.

*Level of subsidy.* The group discussed what level of subsidy the FCC should consider providing to networks in the future through the RHC program. Some noted that the RHC discount rate should be at least 50% in order to be competitive with the discount that telecommunications providers offer urban health care providers. Others stated that lowering the discount rate to 50% would immensely reduce demand for broadband services, and that most rural places could not pay their bills without the current discount rate of 85%. The highest level of contribution that the group felt Pilot projects could support was 25-30% of the entire project (*i.e.*, 70-75% discount level). The group also commented that a flat discount rate was easier to apply than the rural/urban price differential used in the Primary Program. NCTN noted that in North Carolina, many rural areas have no broadband service, and in areas where there is service, the urban/rural price differential is not that big. NCTN also noted that it would be helpful if projects could anticipate funding over the long-term in the Primary Program, *i.e.*, sites would be more enthusiastic about applying to the Primary Program if they knew funding was guaranteed for at least three years, as it is in the Pilot program, instead of having to re-apply each year.

*Consortium filing.* The group noted that an important aspect of the Pilot Program was the opportunity to file as a consortium, and as such, recommended that a reformed RHC program provide opportunities for networks to file as a consortia. A consortium approach, the group explained, takes the administrative burden off of small HCPs that do not have the time or personnel to apply for funds through the RHC program. The group also noted that the ability to bill service providers as a consortium in the Pilot Program was also very helpful.

*Construction.* The group agreed that their core competencies did not include constructing and owning networks. As a result, they chose not to construct and own their physical Pilot project networks, with some small exceptions. Instead, they preferred to lease services from service providers, which allowed the projects to reach many more health care providers than the construction option. However, they all agreed that it was important that the projects had the ability to control what the network looked like when completed.

*Expansion of network to new locations.* All of the participants on the call stated that there are other HCPs interested in joining their Pilot project networks. NCTN estimated that there were about 250-400 HCPs that it would like to add to its network. It also explained that the number of HCPs eligible to join NCTN is increasing because many small for-profit HCPs are being purchased by not-for-profit and public medical groups, and thereby becoming eligible to receive RHC funding. CTN agreed and noted that “hundreds” of eligible entities want to join the RMHN and CHCC networks. Because of this demand, CTN suggested that current projects should be allowed to apply for additional funds to connect additional HCPs. PMHA stated that there were enough qualified HCPs in Pennsylvania to increase the number of HCPs it served by 20-25%. PSPN also noted that there is significant interest by many HCPs in South Carolina to join its network.

*Utility of state-wide networks.* The group also discussed the benefits of state-wide networks and agreed that they encouraged broadband build-out and created economies of scale that incentivized

providers to provide more service. NCTN noted that several of their large non-profit health systems appreciate state-wide networks because it is easy to integrate new HCPs into the network. Additionally, if a HCP leaves the health system, it won't have to change its networking capabilities and can rejoin the network with a new owner. CTN explained that two Regional Health Information Organizations (RHIOs) are using CTN to provide services. CTN further stated that state-wide networks enhance the integration of care, particularly when there are limited resources. Similarly, NCTN noted that having a state-wide network can make it easier to implement Health Information Exchanges (HIE) for HCPs across the state.

*Hurdles in Creating the Network.* The group also discussed several hurdles that they had to overcome in designing and implementing their networks. Some noted that the ineligibility of administrative sites to receive funds was problematic. CTN noted that they were surprised that requests for support for behavioral health centers were treated differently than other sites and that USAC required them to provide additional paperwork to receive support for those sites. CTN also stated that they were surprised at how long it took to get their network built because of the time it took to plan the network and the impact of other external factors, such as weather delays. Others commented that the RFP process caused them some unnecessary delay, particularly when they were seeking bids on services that were already being managed by a service provider. They noted that the RFP process takes a lot of time, and when the RFP was for a service that was already being provided by a service provider, it was likely the same entity would win the bid.

Respectfully submitted,

          /s/            
Christianna Lewis Barnhart  
Attorney Advisor, Telecommunications Access Policy Division, Wireline Competition Bureau